fastpacehealth

Employer Authorization Form

Patient must present Photo ID and Authorization Form at time of service

SECTION I:	PATIENT INFORMATION		
Last Name		First Name	
Date of Birth (MM/DD/YYYY)		SSAN	
SECTION II:	**COMPANY INFORMATION**		
Employer Name		Fast Pace Account #	
Primary Contact		Phone Number	
Address City, State, ZIP		Email	

SECTION III: AUTHORIZED SERVICES (check all that apply for this visit)

- ☐ Urine Collection Only (80306)
- ☐ Observed Fee (99211OF)
- ☐ DOT Physical (99455)
- ☐ Flu Vaccine (90686)
- ☐ Tetanus, (Tdap) (90715)
- ☐ Hep A Titer (86708)
- ☐ Hepatitis Panel 4 (80074)
- ☐ EKG (93000)
- ☐ Visual Acuity Test – Snellen (99173)
- ☐ Pure Tone Audiometry (92551)
- ☐ Federal / DOT (80306)
- ☐ 10 Panel Lab (80306)
- ☐ Pre-Employment Physical (99455ND)
- ☐ Immunization Administration (90471)
- ☐ Hep B Titer (86706)
- ☐ Hepatitis C Panel (87522)
- ☐ TB Gold/Blood (86480)
- ☐ Venipuncture (36415)
- ☐ Color Vision Exam – Ishihara
- ☐ (92283BCS) Non-DOT Physicals
- ☐ Lift test (97161)
- ☐ 10 Panel eScreen Instant (eCup+)(80306)
- ☐ TN Drug Free (80306)
- ☐ Breath Alcohol Test (82075)
- ☐ Fit for Duty Physical (97161)
- ☐ Tetanus, Diphtheria (90714)
- ☐ Hep C Titer (86803)
- ☐ MMR Titer (86735, 86765, 86762)
- ☐ PPD Questionnaire (86580Q)
- ☐ Varicella Titer (86787)
- ☐ Chest X-ray 1 or 2 view (71046)

Employer is a participant of the Federal Drug Free Work Force program: ☐ **Yes (Program requires Lab Based UDS)** ☐ **No**

- ☐ Pre-Employment
- ☐ Reasonable Suspicion
- ☐ Random
- ☐ Post-Accident/Post Injury
- ☐ DOT Return to Work (Observed-Federal COC)

SECTION IV: WORKERS' COMPENSATION

☐ Workers' Compensation Injury Treatment

Date of Injury:_____ Type of Injury: _____

W/C Authorization Number: _____

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier

W/C Carrier Name: _____

W/C Carrier Address: _____

W/C Carrier Phone:_____ W/C Carrier Fax:_____Policy Number:_____

SECTION V: CUSTOMER ACKNOWLEDGEMENT

EMPLOYER: This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature.

X_____ _____ _____ _____

Employer Authorized Signature (Required) **Date** **Employer Printed Name (Required)** **Title**